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DEPARTMENT OF MENTAL HEALTH

SENATE JUDICIARY COMMITTEE

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1. WHAT IS THE ROLE AND AUTHORITY OF THE DEPARTMENT OF MENTAL HEALTH AS MENTAL HEALTH TREATMENT PROVIDER?

The Department of Mental Health (DMH) is a payer and provider of mental health services and is the state mental health authority named in statute to oversee mental health services for Vermonters.[1]

- DMH serves a critical role in oversight of mental health services through designated agencies, specialized services agencies, and designated hospitals.
- DMH also provides direct mental health care and treatment to Vermonters at the Vermont Psychiatric Care Hospital and Middlesex Therapeutic Secure Residential Recovery facility.

DMH relies on partnerships and collaboration as critical tenets of how we work together as a system to best serve vulnerable Vermonters. This includes our human services system, the health care system, the correctional system, and the criminal justice system.

2. WHAT ARE THE STATE AND FEDERAL REGULATIONS THAT DMH MUST COMPLY WITH IN ORDER TO PROVIDE MENTAL HEALTH TREATMENT SERVICES AND MAINTAIN FEDERAL FUNDING INCLUDING THOSE WHO ARE CRIMINALLY COURT INVOLVED?

Tropical Storm Irene in 2011, and the destruction of the Vermont State Hospital, prompted the legislature to create a new vision for Vermont's mental health system of care. One of the core tenants of that system, as well as clinical best practice, is that individuals should receive care in the least restrictive setting available.

DMH must comply with state and federal regulations in order to provide mental health treatment services and maintain federal funding.

[1] 18 V.S.A. § 7201

- As both a payer and provider of mental health services, DMH provides treatment to individuals based on their clinical mental health needs.

- In accordance with Act 79 (2012)[2], DMH is required to provide that care in the least restrictive setting that can meet those needs.

- Vermont Psychiatric Care Hospital (VPCH)is a state-of-the-art acute care hospital designed to assess, treat and monitor people who are experiencing a psychiatric crisis. As an acute care hospital, VPCH is responsible to provide treatment and work to transfer patients to lower levels of care as they progress through treatment.

    - For any patient accessing care at the Vermont Psychiatric Care Hospital or other inpatient hospitals, including those with criminal court involvement, it is not a question of *if* they will return to the community, it is a question of *when*.

- VPCH is a federally funded acute care hospital operated by DMH. As with other hospitals, VPCH must adhere to the rules of the Centers for Medicare and Medicaid Services (CMS) and the Joint Commission in order to maintain certification and accreditation as well as receive federal funding.

    - Once patients are stabilized and/or there is a less restrictive setting appropriate to the person's needs, they no longer meet acute criteria and it is required that they transition to a lower level of care.

    - Hospitals risk receipt of federal funding if they do not comply with this regulation.

- Discharge to the next appropriate, least restrictive, level of care is best clinical practice. It may include the secure residential facility, intensive residential facilities, group homes, or other community-based living situations, including an individual's own apartment/house.

- *CMS and Joint Commission rules require DMH to serve people in the least restrictive settings once they no longer meet acute care criteria.*
- *The US Supreme Court, in the 1999 Olmstead decision, held that "unjustified placement or retention of persons in institutions, severely limiting their exposure to the outside community, constitutes a form of discrimination based on disability"*

[2] "Vermont's mental health system shall provide a coordinated continuum of care by the departments of mental health and of corrections, designated hospitals, designated agencies, and community and peer partners to ensure that individuals with mental health conditions receive care in the most integrated and least restrictive settings available." 18 V.S.A. § 7251(3)

3. WHY IS DMH CONCERNED ABOUT A THREE (3) YEAR INITIAL COMMITMENT PERIOD?

DMH provides and supports mental health services and treatment in our communities and in our hospitals. It is the mental health treatment needs of those in our care that drives what type of treatment they receive, how long they receive it, and where they receive it. DMH believes this core tenant of our mission should remain unchanged.

The vision and requirements set out by the Vermont Legislature in Act 79 on the State level, and CMS and Joint Commission requirements and standards on the federal level, require DMH to provide care to individuals in the least restrictive setting possible. In addition, the United States Supreme Court's 1999 Olmstead decision[3] flushed out state requirements under the American with Disabilities Act in relation to those with mental illnesses. The Supreme Court held that

> "unjustified placement or retention of persons in institutions, severely limiting their exposure to the outside community, constitutes a form of discrimination based on disability prohibited by Title II [of the ADA]."[4]

The court also held that:

> "under Title II of the ADA, States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."[5]

A mandatory three (3) year initial commitment period takes away clinicians' ability to treat individuals in the least restrictive setting and puts DMH in an untenable situation – either we violate this legislation or we violate Act 79, CMS, and Joint Commission requirements and are subject to liability as a result of an Olmstead/ADA lawsuit.

[3] 527 U.S. 581 (1999).
[4] *Id.* at 596.
[5] *Id.* at 607.

4. WHAT ARE THE CLINICAL APPROACHES TO HOSPITAL DISCHARGE DECISION MAKING AND RISK ASSESSMENT AND WHAT TOOLS DOES DMH HAVE TO SUPPORT INDIVIDUALS WITH MENTAL ILLNESS IN THE COMMUNITY INCLUDING THOSE WHO ARE CRIMINALLY COURT INVOLVED?

Discharge Planning

The unique mental health treatment needs of each individual drive what type of treatment they receive, how long they receive it, and where they receive it.

- Discharge from a hospital is a clinical decision and is based on an individual no longer meeting hospital level of care criteria. This is determined by a treating psychiatrist with input from the treatment team.

- Once an individual no longer needs acute mental health care treatment they must be discharged to a lower level of care. The purpose of an inpatient unit is not to assure public safety, it is to assure an individual receives appropriate mental health care treatment.

- A person can be discharged from an inpatient facility and still be under the care and custody of the Commissioner by an order of non-hospitalization (ONH). ONH's provide oversight in an effort to ensure compliance with necessary mental health treatment.

    - The clinical and statutory tools DMH has to provide treatment are based upon a person's clinical mental health needs. The tools are not meant to, nor are they able to, deal with significant criminal conduct and public safety risk.
    - An ONH is a tool to manage risk of harm to self or others due to a mental illness, yet only encourages and facilitates compliance, and as such they are inadequate to manage public safety.

Assessing Risk

Mental health treatment cannot mitigate all risks. Providers, like VPCH and MTCR, can treat an individual's mental illness, but mental health treatment cannot address criminogenic or anti-social behaviors. Those are dynamic factors in determining risk that are best addressed through other kinds of programming.

- Examples of issues best addressed through other kinds of programming include substance abuse, impulse control, anger management issues, history of violent behavior including domestic violence and head injuries.

- It is important to remember that in order for someone to be involuntarily in the custody of DMH, their danger to self or others must be a result of mental illness. Individuals can

be a danger to themselves self or others for many reasons other than mental illness.

What does the data say?
Too often, society labels people who engage in violent behavior as "mentally ill." The vast majority of tragic events have not been perpetrated by individuals with a mental illness.

- *People with mental illness are up to 5 times more likely to be the victim of a crime than to commit one.*
- *Only 3% to 5% of all violence is attributable to a person with a serious mental illness.*

It is tempting to posit that for individuals with mental illness that their crimes are "solely" the result of their mental illness, however it does a disservice to those struggling with mental illness to draw a straight line between mental illness and criminal behavior.

Protected Health Information

As a health care provider and payer, DMH must adhere to laws governing protected health information. As such, DMH is prohibited from disclosing information about patients.

- Under HIPAA, protected health information is considered to be individually identifiable information relating to the past, present, or future health status of an individual that is created, collected, or transmitted, or maintained by a HIPAA-covered entity in relation to the provision of healthcare, payment for healthcare services, or use in healthcare operations.
- Health information such as diagnoses, treatment information, medical test results, and prescription information are considered protected health information under HIPAA, as are national identification numbers and demographic information such as birth dates, gender, ethnicity, and contact and emergency contact information. PHI relates to physical records, while ePHI is any PHI that is created, stored, transmitted, or received electronically.
- Federal and State laws prohibit DMH from disclosing information about patients. However, in certain narrow instances, DMH may disclose certain information:

    - If an individual poses a serious and imminent risk to someone who is identifiable, DMH is permitted to disclose certain information pursuant to HIPAA and Act 51 (2017). Act 51 clarified that "a mental health professional who knows or, based upon the standards of the mental health profession, should know that his or her patient poses a serious risk of danger to an identifiable victim has a duty to exercise reasonable care to protect him or her from that danger."

    - There is **no** general HIPAA exemption that would allow DMH to notify people in the event of discharge from custody where a serious and imminent risk of danger to an identifiable victim is not present.

5. WHY IS DMH CONCERNED WITH A "PUBLIC SAFETY HEARING" AS A REQUIREMENT TO DISCHARGE?

The statutory requirements for committing a person involuntarily to the care and custody of the Commissioner of Mental Health are already clear in Title 18 of the Vermont Statutes. The determination revolves around whether someone is "a person in need of treatment"[6] or "a patient in need of further treatment."[7] These are both clinical decisions, based on whether a person is a danger to themselves or others, *based on a mental illness*. As mentioned above, mental health treatment cannot mitigate all risks. Providers can treat an individual's mental illness, but mental health treatment cannot address criminogenic or anti-social behaviors. Individuals can be a danger to themselves or others for many reasons other than mental illness.

Should a court refuse to allow DMH to discharge a patient from the hospital even though the patient's clinician testified that the person no longer required that level of care, DMH would be in an untenable situation – either we violate this legislation or we violate Act 79, CMS, and Joint Commission requirements and are subject to liability as a result of an Olmstead/ADA lawsuit.

DMH is also concerned with a victim having party status in a commitment hearing. Determinations about whether someone meets criteria to be involuntarily in the care and custody of the Commissioner of Mental Health, either on an Order of Hospitalization or an Order of Non-Hospitalization, are solely clinical decisions based on the statutes in Title 18. The court should only be hearing from mental health professionals on someone's clinical needs and applying the statute to testimony and argument on those clinical needs.

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[6] 18 V.S.A. § 7101(17): "A person in need of treatment" means a person who has a mental illness and, as a result of that mental illness, his or her capacity to exercise self-control, judgment, or discretion in the conduct of his or her affairs and social relations is so lessened that he or she poses a danger of harm to himself, to herself, or to others:
(A) A danger of harm to others may be shown by establishing that:
(i) he or she has inflicted or attempted to inflict bodily harm on another; or
(ii) by his or her threats or actions he or she has placed others in reasonable fear of physical harm to themselves; or
(iii) by his or her actions or inactions he or she has presented a danger to persons in his or her care.
(B) A danger of harm to himself or herself may be shown by establishing that:
(i) he or she has threatened or attempted suicide or serious bodily harm; or
(ii) he or she has behaved in such a manner as to indicate that he or she is unable, without supervision and the assistance of others, to satisfy his or her need for nourishment, personal or medical care, shelter, or self-protection and safety, so that it is probable that death, substantial physical bodily injury, serious mental deterioration, or serious physical debilitation or disease will ensue unless adequate treatment is afforded.

[7] 18 V.S.A. § 7101(16): "A patient in need of further treatment" means:
(A) a person in need of treatment; or
(B) a patient who is receiving adequate treatment, and who, if such treatment is discontinued, presents a substantial probability that in the near future his or her condition will deteriorate and he or she will become a person in need of treatment.

6. WHAT ARE THE ELEMENTS OF A FORENSIC SYSTEM OF CARE? WHAT ARE OTHER STATE'S DOING, AND WHAT STEPS IS DMH TAKING TO HAVE THIS DISCUSSION ON VERMONT?

This moment in time provides an opportunity for Vermont to reflect on and come together around solutions to have a true forensic system of care.

- Psychiatric care for those in various stages of the criminal justice system is commonly called forensic care
- Vermont is an outlier nationally in many regards in terms of our lack of a forensic system of care.
- Some states have forensic systems that are partnerships between mental health, the criminal justice system, and corrections
- Forensic systems often include:
    - Competency restoration programs
        - Competency restoration is the process used when an individual charge with a crime is incompetent to stand trial, competency must be restored before the legal process can continue
    - Discharges that include oversight and monitoring between both mental health and corrections
    - Some states use a board to determine discharge from a hospital comprised of members including mental health practitioners, probation and parole, members of the public and peers.
    - Some states have findings in addition to guilty, innocent, or not guilty by reason of insanity such as Guilty but Mentally Ill.
- **Example: Competency Restoration Programs**
    - Competency Restoration programs must include treatment of underlying mental illness along with a psychoeducational component to restore competency to regain the ability to participate in the resolution of their legal predicaments
    - Services include social and life skills training, case management, mental health services and treatment, and legal education
- **Example: Connecticut Psychiatric Security Review Board**
    - Connecticut established an administrative psychiatric security review board to monitor the post-verdict disposition of defendants found not guilty by reason of mental disease. This was prompted by public concern of procedures for follow-up of insanity acquittees.
    - The PSRB's responsibility is to review the status of acquittees through an administrative hearing process and order the level of supervision and treatment for the acquittee necessary to protect the public
    - The Board is composed of six members appointed by the Governor and are designated to represent:

        - Professional expertise in the field of law, probation/parole services, psychology, psychiatry, victim services and the interest of the general community
    - Judicial review is required before a patient is discharged from the board's custody
    - Regular review of acquittess's progress and intensive community supervision have resulted in a high level of accountability

A robust policy discussion about a forensic system of care would allow Vermont to provide appropriate access to mental health treatment and care for those who are criminally court involved as well as helping to ensure the public safety of Vermonters

DMH is committed to convening partners to:

- Work together to articulate the gaps and opportunities in our current Vermont mental health and criminal justice system structure
- Review existing models and elements of a forensic system of care in other states and providing recommendations for Vermont to advance the implementation of a forensic system of care in Vermont

In a time when resources are too few and problems are complex, we can only find meaningful solutions through collaborative dialogue. We think we can use this opportunity to create positive change for Vermont.

7. MEMORANDUM OF UNDERSTANDING BETWEEN DEPARTMENT OF MENTAL HEALTH AND DEPARTMENT OF CORRECTIONS

DMH has a Memorandum of Understanding (MOU) with the Department of Corrections (DOC) that includes collaboration on mental health services for inmates in DOC custody who have been identified by DOC as requiring a level of care that cannot be adequately provided by DOC, placement of inmates coming into the custody of DMH pursuant to Titles 13 and 18, and inmates voluntarily seeing hospitalization who meet inpatient criteria.

For any of these populations, some examples of care coordination may include:

- Clinical care coordination
- DOC Health Services consulting with DMH clinical staff to aid in augmenting treatment plans for inmates struggling with mental health issues
- DOC consulting with DMH regarding new or alternative treatment modalities for inmates who may have higher needs
- Doctor to doctor consultation around medication management of symptoms for complex inmate presentations
- A warm handoff between providers to ensure that clinical care has continuity; safety and security

- Identifying the most appropriate setting within the correctional facility
- If the individual requires accommodations, we prepare to meet those upon transfer.

ADDITIONAL RESOURCES – IMPORTANT STATUTES AND DEFINITIONS:

Danger to self or others:

18 V.S.A. § 7101(17):

*"A person in need of treatment" means a person who has a mental illness and, **as a result of that mental illness**, his or her capacity to exercise self-control, judgment, or discretion in the conduct of his or her affairs and social relations is so lessened that he or she poses a danger of harm to himself, to herself, or to others…"* (emphasis added)

It is important to note that danger to self or others as a criteria for being a person in need of treatment, and thus needing to be under DMH custody, must be "as a result of that mental illness" per the statute. Individuals certainly can be a danger to themselves or others for many reasons other than mental illness.

Least restrictive level of care

18 V.S.A § 7251(3):

*"Vermont's mental health system shall provide a coordinated continuum of care by the Departments of Mental Health and of Corrections, designated hospitals, designated agencies, and community and peer partners to ensure that individuals with a mental condition or psychiatric disability receive care in the most integrated and **least restrictive settings available**…"* (emphasis added)

Tropical Storm Irene in 2011, and the destruction of the Vermont State Hospital, prompted the legislature to create a new vision for Vermont's mental health system of care. One of the core tenants of that system, as well as clinical best practice, is that individuals should receive care in the least restrictive setting available.

It is important to note that someone could meet criteria for an involuntary status and yet be in the community on an Order of Non-Hospitalization (ONH) because that is the most appropriate and least restrictive treatment setting. In the community does not just mean at the Middlesex Therapeutic Community Residence (MTCR), it could be there to anywhere from an intensive residential facility to an individual's own home.

DMH has approximately 250 people at any time on ONHs, only up to 7 of those could be at MTCR at any one time.

Sanity

***Sanity**: 13 V.S.A. § 4801(a):*

(a) The test when used as a defense in criminal cases shall be as follows:

*(1) A person is not responsible for criminal conduct if **at the time of such conduct** as a result of mental disease or defect he or she lacks adequate capacity either to appreciate the criminality of his or her conduct or to conform his or her conduct to the requirements of law.*

(2) The terms "mental disease or defect" do not include an abnormality manifested only by repeated criminal or otherwise anti-social conduct. The terms "mental disease or defect" shall include congenital and traumatic mental conditions as well as disease. (emphasis added)

Sanity is a point in time assessment related to a potential legal defense. A sanity determination is unrelated to whether an individual meets hospitalization criteria. Someone could well be determined insane at the time of the offence by a court and not meet hospitalization criteria or even involuntary criteria. Sanity is only looking at the time of the conduct, not the individual's current mental health needs.